BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
FRANK D. GILMAN, M.D.	)	**Case No. 800-2016-022170**
Physician's and Surgeon's Certificate No. G58692	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 4, 2019.

IT IS SO ORDERED April 12, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **FRANK D. GILMAN, M.D.** **2001 4th Avenue** **San Diego, CA 92101-2303** **Physician's and Surgeon's Certificate No. G58692** Respondent.	Case No. 800-2016-022170 OAH No. 2018120394 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

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2. Respondent Frank D. Gilman, M.D. (Respondent) is represented in this proceeding by Scott D. Buchholz, Esq., of Dummit, Buchholz & Trapp, whose address is 101 W. Broadway, Suite 1400, San Diego, CA 92101.

3. On or about September 22, 1986, the Board issued Physician's and Surgeon's Certificate No. G58692 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-022170, and will expire on April 30, 2020, unless renewed.

JURISDICTION

4. On October 2, 2018, Accusation No. 800-2016-022170 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 2, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2016-022170 is attached hereto as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-022170. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent agrees that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 800-2016-022170 and that he has thereby subjected his Physician's and Surgeon's Certificate No. G58692 to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G58692 for the Board's formal acceptance with an agreed upon effective date of July 4, 2019.

9. Respondent agrees that his Physician's and Surgeon's Certificate No. G58692 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

10. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G58692, or petitions to revoke probation or if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2016-022170 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G58692 without further notice to, or opportunity to be heard by, Respondent.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license."

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive

Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

17. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Medical Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G58692, issued to Respondent Frank D. Gilman, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order which shall be on July 4, 2019.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-022170 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2016-022170 shall

be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure

ACCEPTANCE

I have carefully read the above Stipulated Surrender and Disciplinary Order and have fully discussed it with my attorney, Scott D. Buchholz, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/3/2019

FRANK D. GILMAN, M.D.
Respondent

I have read and fully discussed with Respondent Frank D. Gilman, M.D., the terms and conditions and other matters contained in the above Stipulated Surrender and Disciplinary Order. I approve its form and content.

DATED: 4/3/19

~~SCOTT D. BUCHHOLZ, ESQ.~~ TARYN PEREZ, ESQ
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 4/3/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-022170

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO October 2 2019
BY: Judy Wright ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **FRANK GILMAN, M.D.** **2001 4th Avenue** **San Diego, California 92101** **Physician's and Surgeon's Certificate No. G58692 ,** Respondent.	Case No. 800-2016-022170 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 22, 1986, the Board issued Physician's and Surgeon's Certificate No. G58692 to Frank Gilman, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on April 30, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . . ."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist,

psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, and D, as more particularly alleged hereinafter:

PATIENT A

9. As of at least February 23, 2007, respondent was treating patient A,[1] a then-60-year old female with a documented history of, among other things, neck pain, major depressive disorder, hypothyroidism, gastroesophageal reflux disease (GERD), and musculoskeletal issues. Respondent treated patient A approximately three more times from February 24, 2007, through the end of 2008.

10. During the period of on or about January 1, 2009, to December 31, 2009, respondent had five (5) office visits with patient A.[2] According to Respondent's progress notes, the visits took place on March 31, May 7, June 10, June 29 and October 21, 2009. Patient A's problems during this time included, but were not limited to, chronic pain, chest pain, fibromyalgia, hypothyroidism, and GERD. Patient A was also being followed by her psychiatrist, Dr. C.M., for mental health issues. According to the CURES report for patient A, the following prescriptions for controlled substances were filled for patient A during 2012:

Filled	Drug Name	Strength	Quantity	Prescriber
02-04-2009	Oxycodone/APAP[3]	10/325 mg	360	Dr. C.M.

[1] Patient A is being used in place of the patient's name or initials to maintain patient confidentiality. The other patients in this Accusation are referred to patients B, C, and D, to also maintain patient confidentiality.

[2] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] Oxycodone/APAP (Percocet®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a (continued...)

Filled	Drug Name	Strength	Quantity	Prescriber
02-23-2009	Temazepam[4]	30 mg	90	Dr. C.M.
04-10-2009	Lorazepam[5]	2 mg	90	Dr. C.M.
06-10-2009	Provigil[6]	200 mg	30	Respondent
06-11-2009	Temazepam	30 mg	90	Dr. C.M.
06-17-2009	Lorazepam	2 mg	90	Dr. C.M.
07-08-2009	Diazepam[7]	10 mg	1	Other
07-29-2009	Provigil	200 mg	90	Dr. C.M.
07-30-2009	Oxycodone[8]	5 mg	900	Dr. C.M.

(...continued)
black box warning for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

[4] Temazepam (Restoril®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Restoril® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Restoril®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[5] Lorazepam (Ativan®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of Ativan® with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Ativan®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

[6] Provigil® (modafinil), is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated it is used to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, or shift work disorder.

[7] Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

Filled	Drug Name	Strength	Quantity	Prescriber
08-31-2009	Temazepam	30 mg	90	Dr. C.M.
09-14-2009	Provigil	200 mg	180	Dr. C.M.
09-14-2009	Lorazepam	2 mg	90	Dr. C.M.
10-28-2009	Roxicet[9]	5/325 mg	900	Dr. C.M.
11-13-2009	Temazepam	30 mg	90	Dr. C.M.
11-20-2009	Lorazepam	2 mg	90	Dr. C.M.
11-23-2009	Oxycodone	5 mg	200	Dr. C.M.
12-30-2009	Alprazolam[10]	1 mg	180	Dr. C.M.

11. During the period of on or about January 1, 2010, to December 31, 2010, respondent had seven (7) office visits with patient A. According to Respondent's progress notes, the visits took place on February 18, May 19, September 2, October 4, October 14, and November 16, 2010. Patient A's problems during this time included, but were not limited to, chronic pain,

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(...continued)

[8] Oxycodone HCL (OxyContin®) is a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Oxycodone HCL is used for the management of pain severe enough to require daily, around-the-clock, long term opioid treatment for which alternative treatment options are inadequate. The DEA has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The risk of respiratory depression and overdose is increased with the concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression.

[9] Roxicet® (oxycodone and acetaminophen), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

[10] Alprazolam (Xanax®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

hypertension (HTN), and depression. During 2010, patient A received electroconvulsive therapy (ECT) to treat severe depression and she was also followed by her psychiatrist, Dr. C.M. According to the CURES report for patient A, the following prescriptions for controlled substances were filled for patient A during 2010:

Filled	Drug Name	Strength	Quantity	Prescriber
01-23-2010	Nuvigil[11]	150 mg	30	Dr. C.M.
02-02-2010	Temazepam	30 mg	90	Dr. C.M.
02-23-2010	Oxycodone	5 mg	900	Dr. C.M.
05-11-2010	Oxycodone	5 mg	900	Dr. C.M.
05-11-2010	Provigil	100 mg	90	Dr. C.M.
05-26-2010	Temazepam	30 mg	90	Respondent
06-08-2010	OxyContin	10 mg	14	Dr. C.M.
06-15-2010	OxyContin	20 mg	63	Dr. C.M.
07-02-2010	Oxycodone	20 mg	360	Dr. C.M.
08-03-2010	Temazepam	30 mg	90	Respondent
09-02-2010	OxyContin	10 mg	60	Respondent
09-03-2010	Alprazolam	1 mg	180	Dr. C.M.
09-07-2010	OxyContin	20 mg	360	Dr. C.M.
10-11-2010	Oxycodone	5 mg	240	Respondent
10-14-2010	Temazepam	30 mg	30	Respondent
11-09-2010	Alprazolam	1 mg	180	Dr. C.M.
11-23-2010	Oxycodone	5 mg	720	Respondent
11-23-2010	OxyContin	20 mg	60	Respondent

[11] Nuvigil® (armodafinil), is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated it is used to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, or shift work disorder.

Filled	Drug Name	Strength	Quantity	Prescriber
12-17-2010	Temazepam	30 mg	90	Respondent

12. During the period of on or about January 1, 2011, to December 31, 2011, respondent had five (5) office visits with patient A. According to respondent's progress notes, the visits took place on January 5, March 2, May 4, July 11, and November 2, 2011. Patient A's problems during this time included, but were not limited to, chronic pain, fibromyalgia, and depression. On November 9, 2011, patient A filled a prescription for Oxycodone 5 mg (#720), the details of which are not accurately documented in patient A's medical record and which respondent could not explain when questioned about the prescription.[12] During this time, patient A was also followed by, a new psychiatrist, Dr. C.C., for her mental health issues. According to the CURES report for patient A, the following prescriptions for controlled substances were filled for patient A during 2011:

Filled	Drug Name	Strength	Quantity	Prescriber
02-18-2011	Temazepam	30 mg	90	Respondent
03-09-2011	OxyContin	20 mg	60	Respondent
03-09-2011	Oxycodone	5 mg	720	Respondent
04-19-2011	Methylphenidate[13]	5 mg	60	Dr. C.C.
05-05-2011	Methylphenidate	10 mg	60	Dr. C.C.

[12] The progress note for the prior visit of November 2, 2011, indicates "Oxycodone HCL 5 MG Oral Tablet; 1-2 TABS Q4-6 HR PRN SEVERE PAIN; Rx." There is no indication of the quantity that is being prescribed and respondent had difficulty explaining the large quantity of oxycodone when asked at his interview before a Department of Consumer Affairs, Health Quality Investigation Unit (HQIU) investigator regarding his care and treatment of patient A. Patient A had previously filled prescriptions from respondent for oxycodone 5 mg (#720) on November 23, 2010, March 9, 2011, and May 9, 2011.

[13] Methylphenidate (Ritalin® and Methylin®), a central nervous system stimulant, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat attention deficit hyperactivity disorder (ADHD) and narcolepsy. According to the DEA, amphetamines, such as methylphenidate, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.)

Filled	Drug Name	Strength	Quantity	Prescriber
05-09-2011	Alprazolam	1 mg	90	Dr. C.C.
05-09-2011	Oxycodone	5 mg	720	Respondent
05-09-2011	OxyContin	20 mg	60	Respondent
05-11-2011	Methylin	10 mg	180	Dr. C.C.
06-01-2011	Temazepam	30 mg	30	Respondent
06-07-2011	Temazepam	30 mg	90	Respondent
06-23-2011	Methylin	20 mg	180	Dr. C.C.
07-15-2011	OxyContin	20 mg	60	Respondent
08-30-2011	Temazepam	30 mg	90	Respondent
09-29-2011	Methylphenidate	20 mg	180	Dr. C.C.
10-19-2011	Methylphenidate	20 mg	270	Dr. C.C.
11-09-2011	OxyContin	20 mg	60	Respondent
11-09-2011	Oxycodone	5 mg	720	Respondent
11-22-2011	Temazepam	30 mg	90	Respondent
12-02-2011	OxyContin	20 mg	60	Respondent

13. During the period of on or about January 1, 2012, to July 1, 2012, respondent had five (5) office visits with patient A. According to respondent's progress notes, the visits took place on January 5, March 2, May 4, July 11, and November 2, 2011. Patient A's problems during this time included, but were not limited to, depression, chronic pain, fibromyalgia, hypothyroidism, and opiate addiction (as noted in her psychiatric records). During this time, patient A continued to be followed by Dr. C.C., for her mental health issues. On January 13, 2012, patient A was admitted to Sharp Grossmont Behavioral Health after a suicide attempt.[14] After consultation, she

[14] According to one of the relevant medical records, "... [t]he patient was transferred here from Sharp Memorial Medical floor for further stabilization and recent suicidality. When I first contacted the patient I did an extensive psychiatric history note for treatment of refractory depression. She has overdosed on 7 temazepam 30 mg tablets because she was 'very depressed.' She states she had been thinking about it for weeks and wrote some sort of suicide note..."

underwent ECT therapy on January 18, January 20, and January 23, 2012. Patient A was discharged on January 24, 2012. On February 5, 2012, patient A's husband reported to respondent that patient A "took 6 temazepam tablets in suicide gesture," that she had been admitted for a mental health evaluation, and that she received three electroconvulsive therapy (ECT) procedures which improved her mood but "increased memory difficulty." On April 22, 2012, patient A self-admitted to Sharp Grossmont Behavioral Health, with the recommendation of her treating psychiatrist, Dr. C.C., for severe depression and suicidal ideation. According to the relevant medical records, patient A was diagnosed as suffering from, among other things, major depressive disorder, recurrent, severe, without psychosis; chronic pain affecting psychological condition; hypothyroidism; and chronic low back pain with degenerative disk disease" and was noted to have a "history of opioid dependence over the last 5 to 6 years..." The treatment plan for Patient A's psychiatric care was additional ECT procedures, which had been tried in the past, because her psychiatric medications were no longer effective in treating her severe depression. Patient A underwent a series of ECT procedures on an outpatient and inpatient basis and was discharged in early May 2012, to be followed by her treating psychiatrist. Patient A's condition on discharge was documented as "stable, improved [and] [w]hile continuing to be quite depressed [patient A] was no longer with acute suicidal ideations." According to the CURES report for patient A, the following prescriptions for controlled substances were filled for patient A during 2012:

Filled	Drug Name	Strength	Quantity	Prescriber
02-22-2012	OxyContin	20 mg	60	Respondent
02-22-2012	Oxycodone	5 mg	240	Respondent
03-08-2012	Methylphenidate	30 mg	60	Respondent
04-05-2012	Methylphenidate	20 mg	270	Dr. C.C.
05-08-2012	OxyContin	20 mg	90	Respondent
05-23-2012	OxyContin	20 mg	90	Respondent
06-02-2012	Methylphenidate	20 mg	180	Dr. C.C.

Filled	Drug Name	Strength	Quantity	Prescriber
06-19-2012	Oxycodone	5 mg	90	Respondent
06-20-2012	OxyContin	20 mg	90	Respondent

14. On or about July 3, 2012, patient A was found dead at her home. Patient A's cause of death was listed as "acute oxycodone, alprazolam, and temazepam intoxication" and the manner of death was listed as suicide.[15]

15. Throughout his course of treatment of patient A, respondent failed to adequately respond to warning signs indicating possible misuse, abuse and/or diversion of controlled substances and did not take adequate risk screening measures to prevent the misuse, abuse and/or the diversion of the controlled substances that he was prescribing. These warning signs included, but were not limited to, overuse of controlled substances and possible diversion by patient A's husband, who was also receiving controlled substances from respondent.[16]

16. Respondent committed gross negligence in his care and treatment of patient A which included, but was not limited to, the following:

(a) Respondent repeatedly increased the risk of harm to patient A through, among other things, his haphazard prescribing of controlled substances to patient A;

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[15] According the Autopsy Report, "Toxicological testing detected a markedly elevated level of oxycodone. Additionally, 72 mg of oxycodone, which would be fifteen 5 mg oxycodone pills, remained in her gastric contents, clearly indicating intentional overdose. Also, detected were alprazolam and temazepam (and its metabolite, oxazepam). No alcohol was detected. [¶] Based on the autopsy findings and the circumstances surrounding the death, as currently understood, the cause of death is acute oxycodone, alprazolam, and temazepam intoxication, and the manner of death is suicide."

[16] During his interview before a HQIU investigator, respondent admitted that patient A would vary her dose on occasion which was due, in part, to respondent's failure to have a clear, rationale, and adequately documented treatment plan for the controlled substances that were being prescribed to patient A. Respondent was also prescribing pain medications to patient A's husband. During his interview, respondent was asked whether he was aware that one of patient A's prescriptions had been filled on July 18, 2012, approximately two weeks after patient A had died. Respondent indicated he was not aware of the prescription that was filled on July 18, 2012. Respondent further admitted during his interview that he was not checking CURES at the time he was treating patient A.

(b) Respondent repeatedly prescribed controlled substances to patient A without discussing and/or documenting adequate informed consent which included, but was not limited to, the risks associated with treating chronic pain with opioids; the risks associated with the concomitant use of opioids, benzodiazepines, and other drug combinations; and the risks associated with prescribing opioids to patient A, who had a history of suicidal thoughts or actions;

(c) Respondent repeatedly failed to utilize risk screening measures to address possible misuse or diversion of controlled substances which included, but was not limited to, failing to check CURES, failing to utilize a pain management contract; failing to conduct urinalysis or other drug screening; failing to properly coordinate prescribing with other prescribers; and failing to utilize other possible risk screening measures; and

(d) Respondent repeatedly failed to maintain accurate and adequate medical records concerning his care and treatment of patient A which included, but was not limited to, failing to document adequate informed consent, failing to document sufficient and accurate information regarding the controlled substances being prescribed to enable, among other things, validation and continuity of care pertaining to the controlled substances that were being prescribed; failing to document the rationale for continuing opioid treatment with patient A after each of her suicide attempts; and failing to document a rationale and clear treatment plan for the controlled substances that were being prescribed to patient A.

PATIENT B

17. According to respondent's progress notes, respondent first started treating patient B, a then-32-year old male, on or about May 16, 2011. Patient B's documented medical history at the time included chronic lumbar neuritis since high school, depression, hypertension, GERD, and

asthma. Patient B reported he was reluctant to have surgery. Current medications were Prevacid 30 mg and Prozac 40 mg. At this visit, prescriptions for oxycodone HCL (OxyContin) 30 mg q 12 (every 12 hours) and hydrocodone/APAP (Norco)[17] q.i.d (four a day) were refilled.

18. During the period of on or about May 17, 2011, to December 31, 2011, respondent had five (5) additional office visits with patient B. According to respondent's progress notes, the visits took place on June 3, June 24, July 11, October 11, and November 14, 2011. Patient B's problems during this time generally included, but were not limited to, alleged chronic pain, depression, elevated liver function test, and dyslipidemia. On June 24, 2011, patient B indicated that he was seeing a new psychiatrist, Dr. T.L., and was motivated to taper his dosage of oxycodone HCL (OxyContin), which was reduced to 40 mg q am (in the morning) and 30 mg q pm (in the evening) [morphine equivalency dose (MED)[18] of 105 mg/day] and was eventually switched to hydrocodone APAP (Norco) 10/325 mg (five per day) [MED of 50 mg/day] and then oxycodone/APAP (Percocet) 7.5/325 mg (up to 5 tablets per day) [MED of 56.25 mg/day]. According to the CURES report for patient B, he filled multiple prescriptions during the

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[17] Hydrocodone/APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4,000 milligrams (4 grams) per day, and often involve more than one acetaminophen containing product."

[18] Morphine equivalency dose (MED) is a value assigned to opioids to represent their relative potencies. MED is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the prescribed opioid. Daily MED is the sum total of all opioids, with conversation factors applied, that are being taken within a 24-hour period, which is used to determine if a patient is at risk of addiction, respiratory depression, or other delirious effects associated with opioids. The process of converting opioid doses to an overall morphine equivalency dose can be accomplished by using a MED calculator or a morphine equivalency table, also known as opioid conversation chart.

remainder of 2011 for, among other things, hydrocodone/APAP 10/325 mg (#240) [MED of 80 mg/day], benzodiazepines (some prescribed by respondent and some by patient B's treating psychiatrist); and methylphenidate (Ritalin) prescribed by the treating psychiatrist.

19. During the period of on or about January 1, 2012, to December 31, 2012, respondent had one (1) office visit with patient B. According to respondent's progress note, the visit took place on June 6, 2012. Patient B's problems during this time generally included, but were not limited to, alleged chronic pain, depression, anxiety, and ADHD. During 2012, patient B was also under the care of his treating psychiatrist, Dr. T.L., who was also prescribing controlled substances. According to the CURES report for patient B, the following prescriptions for controlled substances were filled for patient B during 2012:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2012	Lorazepam	1 mg	90	30	Respondent
01-14-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
01-16-2012	Clonazepam[19]	0.5 mg	90	30	Dr. T.L.
01-16-2012	Methylphenidate	54 mg	60	60	Dr. T.L.
02-10-2012	Hydrocodone/APAP	10/325 mg	240	15	Respondent
02-12-2012	Clonazepam	0.5 mg	90	30	Dr. T.L.
03-02-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
03-10-2012	Lorazepam	1 mg	90	30	Respondent
03-29-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
04-02-2012	Lorazepam	1 mg	90	30	Respondent
04-12-2012	Methylphenidate	54 mg	30	30	Dr. T.L.

[19] Clonazepam (Klonopin®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Klonipin®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-22-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
05-18-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
05-30-2012	Clonazepam	0.5 mg	30	10	Dr. T.L.
05-31-2012	Methylphenidate	54 mg	60	60	Dr. T.L.
06-06-2012	Clonazepam	0.5 mg	90	30	Dr. T.L.
06-06-2012	OxyContin	40 mg	60	30	Respondent
06-11-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
06-29-2012	Clonazepam	0.5 mg	90	30	Dr. T.L.
06-29-2012	OxyContin	40 mg	8	4	Other
07-03-2012	OxyContin	40 mg	60	30	Respondent
07-13-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
07-26-2012	Clonazepam	0.5 mg	90	30	Dr. T.L.
08-01-2012	OxyContin	20 mg	60	30	Respondent
08-01-2012	Methylphenidate	54 mg	60	60	Dr. T.L.
08-07-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
08-21-2012	Clonazepam	0.5 mg	90	30	Dr. T.L.
08-31-2012	OxyContin	20 mg	60	30	Respondent
09-07-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
09-23-2012	Clonazepam	0.5 mg	90	30	Dr. T.L.
10-02-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
10-04-2012	Adderall XR[20]	20 mg	30	30	Dr. T.L.

[20] Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-04-2012	OxyContin	20 mg	60	30	Dr. D.B.[21]
10-18-2012	Clonazepam	0.5 mg	135	30	Dr. T.L.
11-05-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
11-08-2012	Adderall XR	30 mg	30	30	Dr. T.L.
11-12-2012	Clonazepam	0.5 mg	135	30	Dr. T.L.
11-21-2012	OxyContin	20 mg	60	30	Dr. D.B.
12-04-2012	Hydrocodone/APAP	10/325 mg	240	30	Respondent
12-12-2012	Adderall XR	30 mg	30	30	Dr. T.L.
12-22-2012	Clonazepam	0.5 mg	135	30	Dr. T.L.

20. During the period of on or about January 1, 2013, to December 31, 2013, respondent had two (2) office visits with patient B. According to respondent's progress notes, the visits took place on January 17 and September 13, 2013. Patient B's problems during this time generally included, but were not limited to, alleged chronic pain, depression, hypertension, and GERD. According to the CURES report for patient B, the following prescriptions for controlled substances were filled for patient B during 2013:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
01-03-2013	OxyContin	20 mg	60	30	Respondent
01-14-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
01-16-2013	Adderall XR	30 mg	30	30	Dr. T.L.
01-30-2013	OxyContin	20 mg	30	30	Respondent
01-30-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
02-07-2013	Adderall XR	20 mg	60	30	Other
02-11-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.

[21] At his interview before an HQIU investigator, respondent identified Dr. D.B. as one of his partners that would "share call" and cover for him if he was out of the office.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-26-2013	OxyContin	20 mg	60	30	Respondent
02-26-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
03-07-2013	Adderall XR	30 mg	60	30	Dr. T.L.
03-09-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
03-25-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
04-03-2013	OxyContin	20 mg	60	30	Respondent
04-04-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
04-05-2013	Adderall XR	30 mg	60	30	Dr. T.L.
04-21-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
04-29-2013	OxyContin	20 mg	60	30	Respondent
04-29-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
05-09-2013	Adderall XR	30 mg	60	30	Dr. T.L.
05-18-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
05-31-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
06-03-2013	OxyContin	20 mg	60	30	Respondent
06-04-2013	Adderall XR	30 mg	60	30	Dr. T.L.
06-13-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
06-26-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
07-05-2013	OxyContin	20 mg	60	30	Respondent
07-05-2013	Adderall XR	30 mg	60	30	Dr. T.L.
07-15-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
07-22-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
08-16-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
08-20-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
08-23-2013	Adderall XR	30 mg	60	30	Dr. T.L.
08-23-2013	OxyContin	20 mg	60	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
09-13-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
09-21-2013	Adderall XR	30 mg	60	30	Dr. T.L.
09-21-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
09-21-2013	OxyContin	20 mg	60	30	Respondent
10-08-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
10-21-2013	OxyContin	20 mg	60	30	Respondent
11-06-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
11-06-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.
11-12-2013	Adderall XR	30 mg	60	30	Dr. T.L.
11-20-2013	OxyContin	20 mg	60	30	Respondent
12-09-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
12-19-2013	Clonazepam	0.5 mg	135	30	Dr. T.L.

21. During the period of on or about January 1, 2014, to December 31, 2014, respondent had five (5) office visits with patient B. According to respondent's progress notes, the visits took place on January 2, April 14, June 9, July 10, and September 12, 2014. Patient B's problems during this time generally included, but were not limited to, alleged chronic pain, depression, chronic bronchitis, hypertension, hypogonadism, GERD, and ADHD. On the visit of June 9, 2014, patient B reported, among other things, that he had not taken any opiate pain relievers for the last two weeks and "he [was] agreeable to staying off oxycontin and trying tramadol/apap for mild to moderate pain instead of hydrocodone 10 mg/325 mg..." and also complained of "low motivation, low energy and low sex drive" that respondent attributed to "hypogonadism thought secondary to increased weight and chronic opiate use." In response, respondent provided patient B with a tapering schedule[22] with his plan documented as discontinue OxyContin, use

[22] The tapering schedule was on an undated handwritten note from respondent, discovered by patient B's mother after her son had overdosed. Respondent indicated in his interview before a HQIU investigator, that he believed the note was written in 2014 when patient B and respondent discussed "opioid use [as] a contributor to his hypogonadism and decreased sex drive [a]nd he wanted to taper his opiates."

hydrocodone 10/325 mg only as needed for severe pain and "otherwise use of ultracet 37.5 mg/325 one-two tablet every 4-6 hour for pain" and also prescribed testosterone. Despite the fact that the OxyContin was to be discontinued per respondent's chart note for June 9, 2014, a prescription of OxyContin was filled the same day; and despite that hydrocodone 10/325 mg was only to be used "as needed for severe pain" patient B filled additional prescriptions for hydrocodone/APAP 10/325 mg (#240) on June 16, July 25, August 26, and September 25, 2014. At the beginning of 2014, patient B's MED was approximately 140 mg/day and at the end of 2014 was at approximately 80 mg per day. During 2014, patient B filled his prescriptions at approximately seven (7) different pharmacies. According to the CURES report for patient B, the following prescriptions for controlled substances were filled for patient B during 2014:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2014	OxyContin	20 mg	60	30	Respondent
01-05-2014	Adderall XR	30 mg	60	30	Dr. T.L.
01-09-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
01-27-2014	OxyContin	20 mg	60	30	Respondent
02-03-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
02-20-2014	Clonazepam	0.5 mg	135	30	Dr. T.L.
02-21-2014	OxyContin	20 mg	60	30	Respondent
02-27-2014	Hydrocodone/APAP	10/325 mg	240	30	Dr. T.L.
03-19-2014	OxyContin	20 mg	60	30	Respondent
03-24-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
04-07-2014	Clonazepam	0.5 mg	135	30	Dr. T.L.
04-15-2014	Adderall XR	30 mg	60	30	Dr. T.L.
04-16-2014	OxyContin	20 mg	60	30	Respondent
04-23-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
05-09-2014	Clonazepam	0.5 mg	135	30	Dr. T.L.
05-12-2014	OxyContin	20 mg	60	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
05-15-2014	Adderall	30 mg	60	30	Dr. T.L.
05-19-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
06-03-2014	Clonazepam	1 mg	90	30	Dr. T.L.
06-09-2014	Androgel[23]	1.62%	75	30	Respondent
06-09-2014	OxyContin	20 mg	60	30	Respondent
06-15-2014	Adderall	30 mg	60	30	Dr. T.L.
06-16-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
06-28-2014	Clonazepam	1 mg	90	30	Dr. T.L.
07-07-2014	Androgel	1.62%	75	30	Respondent
07-12-2014	Adderall	30 mg	60	30	Dr. T.L.
07-25-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
07-31-2014	Clonazepam	1 mg	90	30	Dr. T.L.
08-10-2014	Androgel	1.62%	75	30	Respondent
08-19-2014	Adderall	30 mg	60	30	Dr. T.L.
08-26-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
08-26-2014	Clonazepam	1 mg	90	30	Dr. T.L.
09-25-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
09-25-2014	Adderall	30 mg	60	30	Dr. T.L.
09-25-2014	Clonazepam	1 mg	90	30	Dr. T.L.
10-11-2014	Androgel	1.62%	75	30	Respondent
10-29-2014	Clonazepam	1 mg	90	30	Dr. T.L.
10-30-2014	Adderall	30 mg	60	30	Dr. T.L.
11-09-2014	Androgel	1.62%	75	30	Respondent

[23] Androgel® (testosterone) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used as a replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
12-04-2014	Androgel	1.62%	75	30	Respondent
12-04-2014	Clonazepam	1 mg	90	30	Dr. T.L.
12-09-2014	Adderall	30 mg	60	30	Dr. T.L.

22. During the period of on or about January 1, 2015, to December 31, 2015, respondent had four (4) office visits with patient B. According to respondent's progress notes, the visits took place on January 9, May 6, October 28, and December 16, 2015. Patient B's problems during this time generally included, but were not limited to, alleged chronic pain, depression, chronic bronchitis, hypertension, hypogonadism, and ADHD. Near the end of 2015, patient B's MED was between 110 to 140 mg/day. During 2015, patient B filled his prescriptions at approximately six (6) different pharmacies. According to the CURES report for patient B, the following prescriptions for controlled substances were filled for patient B during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-03-2015	Clonazepam	1 mg	90	30	Dr. T.L.
01-05-2015	Androgel	1.62%	75	30	Respondent
01-08-2015	Lorazepam	2 mg	30	30	Dr. T.L.
01-08-2015	Vyvanse[24]	70 mg	30	30	Dr. T.L.
01-09-2015	Hydrocodone/APAP	10/325 mg	180	22	Respondent
01-09-2015	Oxycodone	10 mg	90	22	Respondent
03-27-2015	Lorazepam	2 mg	30	30	Dr. T.L.

[24] Vyvanse® (lisdexamfetamine dimesylate), a central nervous system stimulant, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat Attention Deficit Hyperactivity Disorder (ADHD) or moderate to severe binge eating disorder (BED) in adults. According to the DEA, stimulants, such as Vyvanse®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Stimulants are contraindicated for patients with a history of drug abuse. The FDA has issued the following box warning, "Warning Abuse and Dependence [-] CNS stimulants (amphetamines and methylphenidate containing products), including Vyvanse®, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-23-2015	Hydrocodone/APAP	10/325 mg	180	22	Respondent
04-24-2015	Lorazepam	2 mg	30	30	Dr. T.L.
05-12-2015	Adderall	30 mg	30	30	Respondent
05-15-2015	Hydrocodone/APAP	10/325 mg	240	30	Respondent
06-22-2015	Hydrocodone/APAP	10/325 mg	180	30	Respondent
06-30-2015	Lorazepam	1 mg	60	30	Respondent
07-22-2015	Hydrocodone/APAP	10/325 mg	180	30	Dr. D.B.
08-24-2015	Hydrocodone/APAP	10/325 mg	240	30	Respondent
09-17-2015	Lorazepam	1 mg	60	30	Dr. A.P.[25]
09-22-2015	Hydrocodone/APAP	10/325 mg	240	30	Respondent
10-06-2015	Adderall	10 mg	30	30	Respondent
10-12-2015	Oxycodone	10 mg	90	22	Dr. D.B.
10-14-2015	Lorazepam	1 mg	60	30	Dr. D.B.
10-20-2015	Hydrocodone/APAP	10/325 mg	240	30	Respondent
11-02-2015	Adderall	10 mg	30	30	Respondent
11-04-2015	OxyContin	20 mg	60	30	Respondent
11-11-2015	Lorazepam	1 mg	60	30	Respondent
11-16-2015	Hydrocodone/APAP	10/325 mg	240	30	Respondent
11-25-2015	Zolpidem Tartrate	10 mg	30	30	Respondent
12-13-2015	Lorazepam	1 mg	60	30	Respondent
12-15-2015	Hydrocodone/APAP	10/325 mg	240	30	Respondent
12-16-2015	Adderall	10 mg	30	30	Respondent
12-16-2015	OxyContin	10 mg	60	30	Respondent

[25] At his interview before an HQIU investigator, respondent identified Dr. A.P. as one of his partners that would "share call" and cover for him if he was out of the office.

23. During the period of on or about January 1, 2016, to December 31, 2016, respondent had nine (9) office visits with patient B. According to respondent's progress notes, the visits took place on January 22, March 17, May 2, May 11, June 8, June 20, June 27, July 7, and July 28, 2016. Patient B's problems during this time generally included, but were not limited to, alleged chronic pain, depression, anxiety, hypertension, hypogonadism, Stevens-Johnson syndrome (a rare and serious skin and mucous membrane disorder related to severe reaction to medicine), psychotic episode with diagnosis of bipolar disorder, renal insufficiency, pulmonary embolism with brief hospitalization, and ADHD. Beginning in approximately March 2016, patient B was filling prescriptions under two different names, of which respondent was unaware. On May 2, 2016, respondent had a follow up visit with patient B, after patient B suffered a bipolar manic episode and was admitted to UCSD for Stevens-Johnson syndrome secondary to Tegretol. On May 10, 2016, unbeknownst to respondent, patient B filled a prescription for Oxycodone 10 mg (#60) that was prescribed by another prescriber, Dr. M.R. On May 11, 2016, respondent had a follow up visit with patient B, at which time his plan in regard to pain control was documented as "pt. [patient] previously dependent on short term opiate pain relievers [-] pt. has #57 tablets left of oxycodone 10 mg which his wife is dispensing tid [three per day] will use fentanyl patch[26] 50 mcg q 72 hour [one patch every 72 hours] *for one month then discontinue* after short hydrocodone taper." (Emphasis added.) On June 20, 2016, respondent documented, among other things, that "[patient B] last filled clonazepam 1 mg tid #90 on 5/27 *[and] [h]e has already run out*." (Emphasis added.) On July 7, 2016, respondent had a follow up appointment with patient B and documented the following as part of his plan, "pt. requesting pain relief ... Prefer to avoid prn [as needed] pain reliever with [patient B's] past opiate dependence [-] *will use fentanyl 25 mcg patch*

[26] Fentanyl transdermal (Duragesic®) patches are a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated fentanyl transdermal patches are used for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long term opioid treatment and for which alternative treatment options are inadequate. The FDA has issued several black box warnings about fentanyl transdermal patches including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

q 72 hour with goal of discontinuing medication in 4 weeks," which was one-half the dosage of patient B's prior prescription of 50 mcg/hour, with patient B filling the prescription on the same day. (Emphasis added.) On July 28, 2016, respondent had another follow up visit with patient B, in which he noted "[t]he fentanyl patch 25 mcg q 72 hour has helped some but would like to increase to 50 mcg" with respondent doubling the fentanyl patch dosage from 25 mcg/hour back up to 50 mcg/hour,[27] in combination with the clonazepam 1 mg t.i.d. (#90) and zolpidem tartrate (Ambien) 10 mg (#30) that was also being prescribed to him.

24. On or about August 1, 2016, at approximately 3:30 a.m., patient B's mother was awakened when she heard her nine-month old granddaughter crying in her son's room. When she entered her son's room, she saw her son slumped over his bed and not breathing. Patient B's mother called her husband to the room who attempted CPR. 9-1-1 was called. When patient B was moved off his bed a syringe fell to the floor. The autopsy report for patient B lists his cause of death as "Acute Mixed Drug Interaction"[28] and manner of death as "Accident." According to the CURES report for patient B, the following prescriptions for controlled substances were filled for patient B during 2016:

Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-08-2016	Lorazepam	2 mg	30	30	Respondent
01-12-2016	Hydrocodone/APAP	10/325 mg	240	30	Dr. D.B.

[27] At his interview before an HQIU investigator, respondent was asked why he doubled the strength of the fentanyl patch from 25 mcg/hour back up to 50 mcg/hour and respondent replied that patient B advised him that he had doubled up the dose and was using two of the 25 mcg patches. This was not verified, nor was it documented in respondent's chart note. As a result, respondent increased the dosage of the fentanyl patch from 25 mcg/hour to 50 mcg/hour, despite his earlier plan to taper patient B off of the fentanyl patches.

[28] Specifically, the Autopsy Report for patient B states, in pertinent part, "Toxicology testing of peripheral blood detected a potentially toxic concentration of fentanyl (6.8 ng/ml); slightly supratherapeutic concentrations of diphenhydramine (0.13 mg/L), citalopram (0.11 mg/L), and amphetamine (0.14 mg/L); and low concentrations of trazodone (trace), zolpidem (trace) and benzodiazepine metabolite 7-aminoclonazepam (0.07 mg/L). All of the above may have contributed toward central nervous system depression, all are considered contributory toward the death. Amphetamine is included as it many contribute toward deleterious cardiorespiratory effects. Also detected were trace naproxen, warfarin and ibuprofen (which are not felt to be contributory toward the death)."

Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-20-2016	OxyContin	10 mg	60	30	Respondent
01-22-2016	Clonazepam	1 mg	90	30	Respondent
01-25-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
02-04-2016	Lorazepam	2 mg	30	30	Respondent
02-18-2016	Clonazepam	1 mg	90	30	Respondent
02-22-2016	Hydrocodone/APAP	10/325 mg	240	30	Respondent
02-23-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
03-02-2016[29]	Lorazepam	2 mg	30	30	Respondent
03-02-2016	OxyContin	10 mg	60	30	Respondent
03-17-2016	Clonazepam	1 mg	90	30	Respondent
03-20-2016	Hydrocodone/APAP	10/325 mg	240	30	Dr. A.P.
03-29-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
03-31-2016	OxyContin	10 mg	60	30	Respondent
04-11-2016	Clonazepam	1 mg	90	30	Respondent
04-15-2016	Clonazepam	1 mg	42	14	Other
04-19-2016	Adderall	10 mg	30	30	Respondent
04-25-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
05-09-2016	Clonazepam	1 mg	90	30	Respondent
05-10-2016	Oxycodone	10 mg	60	10	Other
05-11-2016	Fentanyl Transdermal	50 mcg/hour	5	15	Respondent
05-25-2016	Adderall	20 mg	30	30	Respondent
05-25-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
05-27-2016	Clonazepam	1 mg	90	30	Respondent

[29] The prescriptions filled from March 2, 2016, through July 19, 2016, were filled with patient B using a different last name. CURES reports were run on both names and the prescriptions under both names are listed in the table above. It is currently unknown whether the use of a different name was pursuant to a legal name change.

Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-21-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
06-24-2016	Clonazepam	1 mg	45	15	Respondent
06-27-2016	Adderall	20 mg	60	30	Other
07-06-2016	Clonazepam	1 mg	45	15	Respondent
07-07-2016	Fentanyl Transdermal	25 mcg/hour	10	30	Respondent
07-19-2016	Zolpidem Tartrate	10 mg	30	30	Respondent
07-19-2016	Clonazepam	1 mg	45	15	Respondent
07-23-2016	Dexedrine[30]	20 mg	60	60	Other
07-28-2016	Fentanyl Transdermal	50 mcg/hour	10	30	Respondent

25. Throughout his course of treatment of patient B, respondent failed to adequately respond to several warning signs indicating misuse, abuse and/or diversion of controlled substances and did not take adequate risk screening measures to prevent the misuse, abuse and/or the diversion of the controlled substances that he was prescribing. These warning signs included, but were not limited to, multiple early refills and overuse of controlled substances.

26. Respondent committed gross negligence in his care and treatment of patient B which included, but was not limited to, the following:

(a) Respondent failed to properly evaluate and manage patient B's chronic nonmalignant pain;

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[30] The prescription for Dexedrine® is actually described by its generic name, dextroamphetamine, in the CURES report. Dexedrine® (dextroamphetamine sulfate) is a central nervous system stimulant of the amphetamine class. Dexedrine® is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of attention-deficit hyperactivity disorder and narcolepsy. The DEA has identified amphetamines, such as Dexedrine®, as drugs of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at pp. 42-44.) The Federal Drug Administration has issued a black box warning for amphetamines which provides that "Amphetamines have a high potential for abuse. Administration of amphetamines for prolonged periods of time may lead to drug dependence and must be avoided. Particular attention should be paid to the possibility of subjects obtaining amphetamines for non-therapeutic use of distribution to others, and the drugs should be prescribed or dispensed sparingly. [¶] Misuse of amphetamines may cause sudden death and serious cardiovascular adverse events." Dexedrine® and other stimulants are contraindicated for patients with a history of drug abuse.

(b) Respondent repeatedly prescribed controlled substances, primarily opioids, to treat patient B's chronic nonmalignant pain without, among other things, sufficiently documenting the effect of patient B's pain on his function and quality of life, without following a rational treatment plan with measurable stated objectives including, but not limited to, pain level and function, and without adjusting treatment pursuant to a rationale and clearly documented treatment plan;

(c) Respondent repeatedly prescribed controlled substances, primarily benzodiazepines, to treat patient B's anxiety without, among other things, a sufficient and clearly documented history, physical examination and/or rationale treatment plan;

(d) Respondent repeatedly prescribed various controlled substances including, but not limited to, opioids, benzodiazepines, and/or other CNS depressants, without providing and documenting adequate informed consent;

(e) Respondent repeatedly prescribed controlled substances including, but not limited to, opioids, benzodiazepines and/or other CNS depressants, without being cognizant of aberrant drug behavior and without timely and adequate risk screening measures to address aberrant drug behavior including, but not limited to, effectively using pain management agreements, periodically reviewing CURES, obtaining information from pharmacies, and/or effectively utilizing pill counts;

(f) Respondent repeatedly increased the risk of harm to patient B, though his concurrent prescribing of opioids, benzodiazepines and/or other CNS depressants;

(g) Respondent excessively prescribed various controlled substances including, but not limited to, opiates, benzodiazepines, and/or other CNS depressants; and

(h) Respondent occasionally exceeded the recommended maximum daily dosage for acetaminophen (APAP).

PATIENT C

27. During the period of on or about January 1, 2013, to December 31, 2013, respondent had one (1) known office visit[31] on July 8, 2013, with patient C, a then-49-year old male. According to the available problem list in medical records, Patient C's problems included, but were not limited to, adrenal cortical adenoma, anxiety, back and neck pain with neuralgia, chest pain, chronic pulmonary embolism, opioid dependence with secondary constipation, hypogonadotropic hypogonadism, hypothyroidism, morbid obesity, osteoarthritis with hip and knee pain, and sleep apnea treated with CPAP, with past surgical history of, among other things, bariatric surgery in February 2012. The progress note for the visit of July 8, 2013, indicates that respondent was attempting to treat Patient C's pain by prescribing him Oxycodone 15 mg (3 tabs every 3 hours – 360 mg/day) which equated to a MED of 540 mg per day. However, unbeknownst to respondent, because he was not checking CURES, patient C was periodically filling prescriptions from respondent on the same days at two different pharmacies and, thus, was getting twice the number of tablets of oxycodone 15 mg which equated to 720 mg/day of oxycodone for a MED of 1,080 mg/day.[32] During the period of June 24 to July 15, 2013 [20 days], patient C obtained 1,328 tablets of oxycodone 15 mg which equated to approximately 66 pills per day for a MED of 1,485 mg per day. According to the CURES report for patient C, the

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[31] As part of its investigation of this matter, the HQIU requested a certified copy of medical records for patient C from respondent. According to the executed Certification of Records form, the certified records covered the period of January 1, 2013, to March 10, 2017, the dates the records were produced. The absence of any progress notes prior to July 8, 2013, was discussed with respondent and his counsel who indicated that "we would have to look into that." No additional records were produced by respondent or his counsel.

[32] As an example, patient C filled prescriptions for oxycodone from different pharmacies on March 25 (total of 332 tabs), April 1 (total of 332 tabs), July 8 (total of 332 tabs), July 15 (total of 498 tabs), August 12 (total of 332 tabs), August 19 (total of 332 tabs), September 16 (total of 332 tabs), October 21 (total of 332 tabs), October 28 (total of 332 tabs), November 4 (total of 332 tabs), and November 18, 2013 (total of 332 tabs). When asked about this at his interview with a HQIU investigator, respondent stated he was not aware that patient B was filling prescriptions at two different pharmacies on the same day because, as previously indicated, he was not checking CURES at the time.

following prescriptions for controlled substances were filled for patient C during 2013:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-03-2013	Oxycodone	20 mg	282	12	Other
01-07-2013	Carisoprodol[33]	350 mg	30	10	Respondent
01-07-2013	Oxycodone	15 mg	166	6	Respondent
01-10-2013	Oxycodone	20 mg	176	8	Other
01-14-2013	Clonazepam	1 mg	30	30	Respondent
01-14-2013	Oxycodone	15 mg	166	6	Respondent
01-14-2013	Diazepam	10 mg	60	30	Other
01-17-2013	Oxycodone	20 mg	160	10	Other
01-17-2013	Fentanyl Transdermal	25 mcg/hour	10	30	Other
01-21-2013	Oxycodone	15 mg	166	6	Respondent
01-25-2013	Hydrocodone/APAP	5/325 mg	50	8	Respondent
01-28-2013	Oxycodone	15 mg	166	6	Respondent
02-01-2013	Oxycodone	20 mg	90	30	Other
02-04-2013	Oxycodone	15 mg	166	7	Respondent
02-11-2013	Alprazolam	0.5 mg	90	30	Respondent
02-11-2013	Carisoprodol	350 mg	90	30	Respondent
02-11-2013	Clonazepam	2 mg	30	30	Respondent
02-11-2013	Oxycodone	15 mg	166	8	Respondent

[33] Carisoprodol (Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of acute and painful musculoskeletal conditions. Soma® is commonly used by those who abuse opioids to potentiate the euphoric effect of opioids, to create a better "high." According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States. According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-12-2013	Clonazepam	1 mg	30	30	Respondent
02-12-2013	Diazepam	10 mg	60	30	Other
02-18-2013	Oxycodone	15 mg	166	7	Respondent
02-25-2013	Oxycodone	15 mg	166	7	Respondent
03-04-2013	Oxycodone	15 mg	166	7	Respondent
03-11-2013	Oxycodone	15 mg	166	7	Respondent
03-13-2013	Clonazepam	1 mg	30	30	Respondent
03-18-2013	Oxycodone	15 mg	166	6	Respondent
03-25-2013	Oxycodone	15 mg	166	7	Respondent
03-25-2013	Oxycodone	15 mg	166	7	Respondent
03-27-2013	Alprazolam	0.5 mg	90	30	Respondent
03-31-2013	Diazepam	10 mg	60	30	Other
04-01-2013	Oxycodone	15 mg	166	7	Respondent
04-01-2013	Oxycodone	15 mg	166	7	Respondent
04-08-2013	Oxycodone	15 mg	166	7	Respondent
04-15-2013	Oxycodone	15 mg	166	7	Respondent
04-22-2013	Oxycodone	15 mg	166	11	Respondent
04-24-2013	Alprazolam	0.5 mg	90	30	Respondent
04-26-2013	Carisoprodol	350 mg	90	30	Respondent
04-26-2013	Clonazepam	2 mg	30	30	Respondent
04-29-2013	Oxycodone	15 mg	166	30	Respondent
05-06-2013	Oxycodone	15 mg	166	8	Respondent
05-13-2013	Oxycodone	15 mg	166	7	Respondent
05-20-2013	Carisoprodol	350 mg	90	30	Respondent
05-20-2013	Clonazepam	2 mg	30	30	Respondent
05-20-2013	Oxycodone	15 mg	332	14	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
05-22-2013	Testosterone	Unknown	10	70	Other
05-22-2013	Compound	Unknown	10	70	Other
06-03-2013	Oxycodone	15 mg	166	7	Respondent
06-04-2013	Lunesta	3 mg	30	30	Respondent
06-10-2013	Oxycodone	15 mg	166	7	Respondent
06-17-2013	Oxycodone	15 mg	166	7	Respondent
06-19-2013	Testosterone	Unknown	10	70	Other
06-19-2013	Compound	Unknown	10	70	Other
06-20-2013	Clonazepam	2 mg	30	30	Respondent
06-20-2013	Carisoprodol	350 mg	90	30	Respondent
06-20-2013	Alprazolam	0.5 mg	90	30	Respondent
06-20-2013	Diazepam	10 mg	100	30	Other
06-24-2013	Oxycodone	15 mg	166	7	Respondent
07-01-2013	Oxycodone	15 mg	166	7	Respondent
07-08-2013	Oxycodone	15 mg	166	7	Respondent
07-08-2013	Oxycodone	15 mg	166	7	Respondent
07-15-2013	Oxycodone	15 mg	166	7	Respondent
07-15-2013	Oxycodone	15 mg	166	7	Respondent
07-15-2013	Oxycodone	15 mg	332	36	Respondent
07-22-2013	Alprazolam	0.5 mg	90	30	Other
07-22-2013	Oxycodone	15 mg	166	7	Respondent
07-22-2013	Carisoprodol	350 mg	90	30	Respondent
07-22-2013	Clonazepam	2 mg	30	30	Respondent
08-06-2013	Clonazepam	1 mg	30	30	Respondent
08-06-2013	Testosterone	Unknown	10	70	Other
08-06-2013	Compound	Unknown	10	70	Other

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
08-12-2013	Oxycodone	15 mg	166	7	Respondent
08-12-2013	Oxycodone	15 mg	166	7	Respondent
08-19-2013	Oxycodone	15 mg	166	7	Respondent
08-19-2013	Oxycodone	15 mg	166	7	Respondent
08-22-2013	Lunesta	3 mg	30	30	Respondent
08-23-2013	Alprazolam	0.5 mg	90	30	Respondent
08-23-2013	Carisoprodol	350 mg	90	30	Respondent
08-23-2013	Clonazepam	2 mg	30	30	Respondent
08-26-2013	Oxycodone	15 mg	166	7	Respondent
09-03-2013	Oxycodone	15 mg	166	30	Respondent
09-09-2013	Oxycodone	15 mg	166	7	Respondent
09-10-2013	Clonazepam	1 mg	30	30	Respondent
09-14-2013	Carisoprodol	350 mg	90	30	Respondent
09-16-2013	Oxycodone	15 mg	166	7	Respondent
09-16-2013	Oxycodone	15 mg	166	7	Respondent
09-17-2013	Diazepam	10 mg	90	90	Other
09-23-2013	Oxycodone	15 mg	166	7	Respondent
10-07-2013	Compound	Unknown	10	70	Other
10-07-2013	Testosterone	Unknown	10	70	Other
10-07-2013	Oxycodone	15 mg	166	7	Respondent
10-13-2013	Clonazepam	1 mg	30	30	Respondent
10-21-2013	Clonazepam	2 mg	30	30	Respondent
10-21-2013	Oxycodone	15 mg	166	7	Respondent
10-21-2013	Oxycodone	15 mg	166	7	Respondent
10-23-2013	Alprazolam	0.5 mg	90	30	Respondent
10-23-2013	Lunesta	3 mg	30	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
10-28-2013	Oxycodone	15 mg	166	7	Respondent
10-28-2013	Oxycodone	15 mg	166	7	Respondent
11-04-2013	Oxycodone	15 mg	166	7	Respondent
11-04-2013	Oxycodone	15 mg	166	7	Respondent
11-06-2013	Testosterone	Unknown	10	70	Other
11-06-2013	Compound	Unknown	10	70	Other
11-11-2013	Oxycodone	15 mg	166	7	Respondent
11-12-2013	Carisoprodol	350 mg	90	30	Respondent
11-15-2013	Clonazepam	1 mg	30	30	Respondent
11-18-2013	Oxycodone	15 mg	166	7	Respondent
11-18-2013	Oxycodone	15 mg	166	7	Respondent
11-22-2013	Clonazepam	2 mg	30	30	Respondent
11-22-2013	Lunesta	3 mg	30	30	Respondent
11-22-2013	Alprazolam	0.5 mg	90	30	Respondent
11-25-2013	Oxycodone	15 mg	166	7	Respondent
12-02-2013	Oxycodone	15 mg	166	7	Respondent
12-09-2013	Oxycodone	15 mg	166	7	Respondent
12-09-2013	Carisoprodol	350 mg	90	30	Respondent
12-10-2013	Diazepam	10 mg	90	90	Other
12-11-2013	Clonazepam	1 mg	30	30	Respondent
12-16-2013	Oxycodone	15 mg	166	7	Respondent
12-18-2013	Alprazolam	0.5 mg	90	30	Respondent
12-23-2013	Clonazepam	2 mg	30	30	Respondent
12-23-2013	Oxycodone	15 mg	166	7	Respondent
12-23-2013	Lunesta	3 mg	30	30	Respondent
12-26-2013	Oxycodone	15 mg	166	7	Respondent

28. During the period of on or about January 1, 2014, to December 31, 2014, respondent had two (2) office visits with patient C. According to respondent's progress notes, the visits took place on June 3 (almost eleven months since his last visit with respondent) and September 12, 2014 (pre-operative visit for upcoming cervical surgery). Patient C's problems during this time generally included, but were not limited to, obesity, osteoarthritis, spinal stenosis, hypogonadism, hypothyroidism, and GERD. During 2014, patient C continued his practice of filling some of his prescriptions for oxycodone on the same day at two different pharmacies which, once again, doubled the amount of pills he was supposed to receive on those dates and increased his MED from 540 mg per day to 1,080 mg per day.[34] On September 8, 2014, respondent was given a phone message from a pharmacist indicating that he was "concerned with [patient C] and the recent early refills." On November 3, 2014, patient C underwent extensive back surgery that was performed by Dr. S.L. at Scripps Memorial Hospital to address severe cervical spondylosis, posterior cervical segmental instability, and severe thoracic stenosis with cord compression and severe thoracic degenerative spondylosis. According to the CURES report for patient C, the following prescriptions for controlled substances were filled for patient C during 2014:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2014	Promethazine Codeine Syrup	6.25 mg/5 ml to 10 mg/5 ml	120	2	Other
01-02-2014	Oxycodone	15 mg	166	7	Respondent
01-06-2014	Oxycodone	15 mg	166	7	Respondent
01-09-2014	Oxycodone	15 mg	166	7	Respondent
01-10-2014	Carisoprodol	350 mg	90	30	Respondent
01-20-2014	Oxycodone	15 mg	166	7	Respondent

[34] As an example, patient C filled prescriptions for oxycodone 15 mg from the Hillcrest and Priority pharmacies on January 2 (total of 332 tabs), March 17 (total of 332 tabs), March 24 (total of 332 tabs), March 31 (total of 332 tabs), April 7 (total of 332 tabs), May 5 (total of 332 tabs), July 10 (total of 498 tabs), November 20 (total of 332 tabs), November 21 (150 tabs of 15 mg and 150 tabs of 30 mg) and November 26, 2014 (total of 332 tabs).

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-21-2014	Testosterone-M[35]	Unknown	10	50	Other
01-21-2014	Testosterone-P[36]	Unknown	10	50	Other
01-22-2014	Clonazepam	2 mg	30	30	Respondent
01-27-2014	Oxycodone	15 mg	166	7	Respondent
02-03-2014	Oxycodone	15 mg	332	14	Respondent
02-03-2014	Alprazolam	0.5 mg	90	30	Respondent
02-03-2014	Oxycodone	15 mg	166	7	Respondent
02-04-2014	Carisoprodol	350 mg	90	30	Respondent
02-13-2014	Oxycodone	15 mg	166	7	Respondent
02-17-2014	Oxycodone	15 mg	166	7	Respondent
02-20-2014	Oxycodone	15 mg	166	7	Respondent
02-21-2014	Clonazepam	2 mg	30	30	Respondent
02-24-2014	Oxycodone	15 mg	166	7	Respondent
02-27-2014	Oxycodone	15 mg	166	7	Respondent
03-03-2014	Oxycodone	15 mg	166	7	Respondent
03-03-2014	Carisoprodol	350 mg	90	30	Respondent
03-06-2014	Alprazolam	0.5 mg	90	30	Respondent
03-10-2014	Oxycodone	15 mg	166	7	Respondent
03-17-2014	Oxycodone	15 mg	166	7	Respondent
03-17-2014	Oxycodone	15 mg	166	7	Respondent
03-24-2014	Oxycodone	15 mg	166	7	Respondent
03-24-2014	Oxycodone	15 mg	166	7	Respondent
03-27-2014	Carisoprodol	350 mg	30	30	Respondent
03-31-2014	Oxycodone	15 mg	166	7	Respondent

[35] Testosterone-M is abbreviated for Testosterone Micronized.

[36] Testosterone-P is abbreviated for Testosterone Propionate.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
03-31-2014	Oxycodone	15 mg	166	7	Respondent
04-03-2014	Alprazolam	0.5 mg	90	30	Respondent
04-07-2014	Oxycodone	15 mg	166	7	Respondent
04-07-2014	Oxycodone	15 mg	166	7	Respondent
04-14-2014	Oxycodone	15 mg	166	7	Respondent
04-21-2014	Carisoprodol	350 mg	90	30	Respondent
04-21-2014	Oxycodone	15 mg	166	7	Respondent
04-21-2014	Clonazepam	2 mg	30	30	Respondent
04-21-2014	Oxycodone	15 mg	166	7	Respondent
04-28-2014	Oxycodone	15 mg	166	7	Respondent
04-28-2014	Oxycodone	15 mg	166	7	Respondent
05-05-2014	Oxycodone	15 mg	166	7	Respondent
05-05-2014	Oxycodone	15 mg	166	7	Respondent
05-06-2014	Alprazolam	0.5 mg	90	30	Respondent
05-12-2014	Oxycodone	15 mg	166	7	Respondent
05-16-2014	Clonazepam	2 mg	30	30	Respondent
05-19-2014	Oxycodone	15 mg	166	7	Respondent
05-23-2014	Carisoprodol	350 mg	90	30	Respondent
05-23-2014	Oxycodone	15 mg	166	7	Dr. H.W.[37]
05-27-2014	Oxycodone	15 mg	166	7	Respondent
06-02-2014	Oxycodone	15 mg	166	7	Respondent
06-05-2014	Oxycodone	15 mg	166	7	Respondent
06-10-2014	Alprazolam	0.5 mg	90	30	Dr. H.W.
06-10-2014	Hydrocodone/APAP	5/325 mg	25	3	Other

[37] At his interview before an HQIU investigator, respondent identified Dr. H.W. as one of his partners that would "share call" and cover for him if he was out of the office.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
06-10-2014	Oxycodone	15 mg	166	7	Respondent
06-12-2014	Oxycodone	15 mg	166	7	Respondent
06-16-2014	Carisoprodol	350 mg	90	30	Respondent
06-16-2014	Clonazepam	2 mg	30	30	Respondent
06-19-2014	Oxycodone	15 mg	166	7	Respondent
06-20-2014	Diazepam	10 mg	90	90	Other
06-26-2014	Oxycodone	15 mg	166	6	Respondent
06-27-2014	Testosterone-P	Unknown	10	50	Other
06-27-2014	Testosterone-M	Unknown	10	50	Other
07-03-2014	Oxycodone	15 mg	166	6	Respondent
07-07-2014	Alprazolam	0.5 mg	90	30	Dr. H.W.
07-10-2014	Oxycodone	15 mg	332	14	Respondent
07-10-2014	Oxycodone	15 mg	166	7	Respondent
07-11-2014	Carisoprodol	350 mg	90	30	Respondent
07-17-2014	Oxycodone	15 mg	166	30	Respondent
07-18-2014	Clonazepam	2 mg	30	30	Other
07-21-2014	Oxycodone	15 mg	332	30	Respondent
08-01-2014	Oxycodone	15 mg	166	30	Respondent
08-08-2014	Testosterone-M	Unknown	10	50	Other
08-08-2014	Testosterone-P	Unknown	10	50	Other
08-09-2014	Carisoprodol	350 mg	90	30	Respondent
08-09-2014	Clonazepam	2 mg	30	30	Dr. H.W.
08-11-2014	Oxycodone	15 mg	166	7	Respondent
08-18-2014	Oxycodone	15 mg	166	7	Respondent
08-25-2014	Testosterone-M	Unknown	10	50	Other
08-25-2014	Testosterone-P	Unknown	10	50	Other

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
08-29-14	Diazepam	10 mg	90	90	Other
09-22-2014	Oxycodone	15 mg	166	7	Respondent
10-03-2014	Oxycodone	15 mg	332	14	Dr. H.W.
10-23-2014	Oxycodone	15 mg	166	7	Respondent
10-30-2014	Oxycodone	15 mg	166	7	Respondent
11-06-2014	Alprazolam	1 mg	60	30	Respondent
11-06-2014	Clonazepam	2 mg	30	30	Respondent
11-06-2014	Oxycodone	15 mg	166	7	Respondent
11-09-2014	Diazepam	10 mg	56	14	Other
11-09-2014	Carisoprodol	350 mg	42	14	Other
11-09-2014	Oxycodone	30 mg	112	14	Other
11-09-2014	OxyContin	10 mg	28	14	Other
11-09-2014	Oxycodone	30 mg	112	14	Other
11-09-2014	OxyContin	20 mg	28	14	Other
11-13-2014	Oxycodone	15 mg	166	7	Respondent
11-20-2014	Carisoprodol	350 mg	90	30	Dr. A.P.
11-20-2014	Oxycodone	15 mg	166	7	Respondent
11-20-2014	Oxycodone	15 mg	166	7	Respondent
11-21-2014	Oxycodone	15 mg	150	19	Dr. S.L.
11-21-2014	Oxycodone	30 mg	150	19	Dr. S.L.
11-21-2014	Diazepam	10 mg	90	45	Dr. S.L.
11-21-2014	OxyContin	20 mg	90	30	Dr. S.L.
11-21-2014	OxyContin	10 mg	90	45	Dr. S.L.
11-21-2014	Carisoprodol	350 mg	90	30	Dr. S.L.
11-26-2014	Oxycodone	15 mg	166	7	Respondent
11-26-2014	Oxycodone	15 mg	166	7	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
12-04-2014	Clonazepam	2 mg	30	30	Respondent
12-04-2014	Alprazolam	1 mg	60	30	Respondent
12-04-2014	Oxycodone	15 mg	166	7	Respondent
12-11-2014	Oxycodone	15 mg	166	7	Respondent
12-11-2014	Oxycodone	15 mg	100	12	Other
12-11-2014	Oxycodone	30 mg	100	12	Other
12-15-2014	Carisoprodol	350 mg	90	30	Dr. S.L.
12-15-2014	Diazepam	10 mg	60	30	Dr. S.L.
12-18-2014	Oxycodone	15 mg	166	21	Respondent
12-18-2014	Carisoprodol	350 mg	90	30	Dr. A.P.
12-22-2014	Testosterone-P	Unknown	10	30	Other
12-22-2014	Testosterone-M	Unknown	10	30	Other
12-23-2014	Oxycodone	15 mg	166	7	Respondent
12-23-2014	Oxycodone	30 mg	120	18	Other
12-23-2014	Oxycodone	15 mg	120	15	Other

29. During the period of on or about January 1, 2015, to December 31, 2015, respondent had two (2) office visits with patient C. According to respondent's progress notes, the visits took place on October 26 and December 11, 2015. Patient C's problems during this time generally included, but were not limited to, post-operative recovery from multilevel laminectomy with stabilization, osteoarthritis (improved with weight loss), hypogonadism, hypothyroidism, and GERD. Respondent continued patient C on oxycodone 15 mg (3 tabs every 3 hours) 360 mg/day [MED of 540 mg per day] which he inaccurately documented as "390 mg of oxycodone per day (45 mg taken q 3 hours)" in his progress note of October 26, 2015. On December 11, 2015, respondent inaccurately documented "pt. continued 390 mg of oxycodone per day," when patient C was actually taking 360 mg per day, and also noted "[c]ontinue to consider taper when ready." During 2015, respondent was prescribing a combination of opioids, benzodiazepines, and

carisoprodol (Soma), a dangerous drug combination known as the "holy trinity."[38] According to the CURES report for patient C, the following prescriptions for controlled substances were filled for patient C during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-02-2015	Diazepam	10 mg	90	45	Other
01-07-2015	Oxycodone	15 mg	166	7	Respondent
01-07-2015	Oxycodone	30 mg	120	8	Other
01-14-2015	Carisoprodol	350 mg	90	30	Other
01-14-2015	Oxycodone	15 mg	166	7	Respondent
01-21-2015	Oxycodone	15 mg	166	7	Respondent
01-21-2015	Oxycodone	30 mg	120	20	Other
01-21-2015	Oxycodone	15 mg	120	20	Other
01-27-2015	Carisoprodol	350 mg	90	30	Other
01-28-2015	Oxycodone	15 mg	166	6	Respondent
01-28-2015	Clonazepam	2 mg	30	30	Respondent
01-28-2015	Alprazolam	1 mg	60	30	Respondent
02-02-2015	Testosterone-M	Unknown	10	30	Other
02-02-2015	Testosterone-P	Unknown	10	30	Other
02-04-2015	Oxycodone	15 mg	166	7	Respondent
02-10-2015	Oxycodone	30 mg	120	20	Other
02-10-2015	Oxycodone	15 mg	120	20	Other
02-11-2015	Oxycodone	15 mg	166	7	Respondent
02-11-2015	Carisoprodol	350 mg	90	30	Dr. A.P.

[38] "Taking these three drugs in combination is typically not medically justified. When taken together these medications may give users a feeling of euphoria similar to heroin. As a result, this prescription drug combination, which may be referred to as 'Houston Cocktail,' 'Holy Trinity,' or 'Trio,' is subject to abuse and has resulted in deaths." (M. Forrester, Ingestions of Hydrocodone, Carisoprodol, and Alprazolam in Combination Reported to Texas Poison Centers, Journal of Addictive Diseases, 30:110-115, 2011.)

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-18-2015	Oxycodone	15 mg	166	7	Respondent
02-24-2015	Diazepam	10 mg	90	30	Other
02-24-2015	Carisoprodol	350 mg	90	30	Other
02-25-2015	Oxycodone	15 mg	166	7	Respondent
02-25-2015	Clonazepam	2 mg	30	30	Respondent
02-25-2015	Alprazolam	1 mg	60	30	Respondent
02-26-2015	Oxycodone	30 mg	120	30	Other
02-26-2015	Oxycodone	15 mg	120	20	Other
03-16-2015	Oxycodone	15 mg	120	20	Other
03-16-2015	Oxycodone	30 mg	120	20	Other
03-17-2015	Oxycodone	15 mg	166	7	Respondent
03-19-2015	Testosterone-P	Unknown	10	30	Other
03-19-2015	Testosterone-M	Unknown	10	30	Other
03-23-2015	Clonazepam	2 mg	30	30	Respondent
03-24-2015	Alprazolam	1 mg	60	30	Respondent
03-24-2015	Oxycodone	15 mg	166	7	Respondent
03-25-2015	Carisoprodol	350 mg	90	30	Other
03-26-2015	Diazepam	10 mg	90	30	Other
03-31-2015	Oxycodone	15 mg	166	7	Respondent
04-03-2015	Oxycodone	15 mg	70	12	Other
04-03-2015	Oxycodone	30 mg	70	12	Other
04-07-2015	Carisoprodol	350 mg	90	30	Other
04-07-2015	Oxycodone	15 mg	166	7	Respondent
04-14-2015	Oxycodone	15 mg	166	30	Respondent
04-14-2015	Oxycodone	15 mg	166	7	Respondent
04-21-2015	Oxycodone	15 mg	166	7	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
04-21-2015	Clonazepam	2 mg	30	30	Respondent
04-21-2015	Alprazolam	1 mg	60	30	Respondent
04-21-2015	Oxycodone	15 mg	166	7	Respondent
04-27-2015	Testosterone-P	Unknown	10	12	Other
04-27-2015	Testosterone-M	Unknown	10	12	Other
04-28-2015	Oxycodone	15 mg	166	7	Respondent
04-28-2015	Oxycodone	15 mg	166	7	Respondent
05-12-2015	Oxycodone	15 mg	166	7	Respondent
05-18-2015	Alprazolam	1 mg	60	30	Respondent
05-19-2015	Oxycodone	15 mg	166	7	Respondent
05-19-2015	Clonazepam	2 mg	30	30	Respondent
05-19-2015	Oxycodone	15 mg	166	7	Respondent
05-26-2015	Oxycodone	15 mg	166	7	Respondent
06-02-2015	Carisoprodol	350 mg	90	30	Respondent
06-02-2015	Oxycodone	15 mg	166	7	Respondent
06-09-2015	Oxycodone	15 mg	166	7	Respondent
06-15-2015	Oxycodone	15 mg	166	7	Respondent
06-17-2015	Alprazolam	1 mg	60	30	Respondent
06-17-2015	Clonazepam	2 mg	30	30	Respondent
06-22-2015	Oxycodone	15 mg	166	7	Respondent
06-23-2015	Oxycodone	15 mg	166	7	Respondent
06-29-2015	Oxycodone	15 mg	166	7	Respondent
06-29-2015	Carisoprodol	350 mg	90	30	Respondent
06-30-2015	Oxycodone	15 mg	166	7	Respondent
07-06-2015	Oxycodone	15 mg	166	7	Respondent
07-07-2015	Oxycodone	15 mg	166	7	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
07-13-2015	Clonazepam	2 mg	30	30	Respondent
07-13-2015	Oxycodone	15 mg	166	7	Respondent
07-13-2015	Alprazolam	1 mg	60	30	Respondent
07-20-2015	Oxycodone	15 mg	166	7	Respondent
07-27-2015	Carisoprodol	350 mg	90	30	Respondent
07-27-2015	Oxycodone	15 mg	166	7	Respondent
08-03-2015	Oxycodone	15 mg	166	7	Respondent
08-03-2015	Oxycodone	15 mg	166	7	Respondent
08-10-2015	Alprazolam	1 mg	60	30	Respondent
08-10-2015	Clonazepam	2 mg	30	30	Respondent
08-10-2015	Oxycodone	15 mg	166	7	Respondent
08-10-2015	Oxycodone	15 mg	332	7	Respondent
08-21-2015	Carisoprodol	350 mg	90	30	Respondent
08-24-2015	Oxycodone	15 mg.	166	7	Respondent
08-31-2015	Oxycodone	15 mg	166	7	Respondent
09-01-2015	Testosterone-P	Unknown	10	12	Other
09-01-2015	Testosterone-M	Unknown	10	12	Other
09-03-2015	Oxycodone	15 mg	166	7	Dr. A.P.
09-08-2015	Clonazepam	2 mg	30	30	Respondent
09-08-2015	Alprazolam	1 mg	60	30	Respondent
09-08-2015	Oxycodone	15 mg	166	7	Respondent
09-14-2015	Oxycodone	15 mg	166	7	Respondent
09-14-2015	Oxycodone	15 mg	166	7	Respondent
09-16-2015	Carisoprodol	350 mg	90	30	Respondent
09-18-2015	Codeine Syrup	10 mg/5 ml to 100 mg/5 ml	240	4	Dr. D.B.
09-21-2015	Oxycodone	15 mg	166	7	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
09-21-2015	Oxycodone	15 mg	166	7	Respondent
09-28-2015	Oxycodone	15 mg	166	7	Respondent
10-05-2015	Clonazepam	2 mg	30	30	Respondent
10-05-2015	Oxycodone	15 mg	166	7	Respondent
10-05-2015	Alprazolam	1 mg	60	30	Respondent
10-12-2015	Carisoprodol	350 mg	90	30	Respondent
10-12-2015	Oxycodone	15 mg	166	7	Respondent
10-19-2015	Oxycodone	15 mg	166	7	Respondent
10-19-2015	Oxycodone	15 mg	166	7	Respondent
10-26-2015	Oxycodone	15 mg	166	7	Respondent
10-26-2015	Oxycodone	15 mg	166	21	Respondent
11-02-2015	Clonazepam	2 mg	30	30	Respondent
11-02-2015	Oxycodone	15 mg	166	7	Respondent
11-02-2015	Alprazolam	1 mg	60	30	Respondent
11-02-2015	Oxycodone	15 mg	166	7	Respondent
11-05-2015	Testosterone-M	Unknown	10	70	Other
11-05-2015	Testosterone-P	Unknown	10	70	Other
11-09-2015	Carisoprodol	350 mg	90	30	Respondent
11-09-2015	Oxycodone	15 mg	166	7	Respondent
11-09-2015	Oxycodone	15 mg	166	7	Respondent
11-16-2015	Oxycodone	15 mg	166	7	Respondent
11-23-2015	Oxycodone	15 mg	166	7	Respondent
11-25-2015	Oxycodone	15 mg	166	7	Respondent
11-25-2015	Alprazolam	1 mg	60	30	Respondent
11-30-2015	Clonazepam	2 mg	30	30	Respondent
12-04-2015	Carisoprodol	350 mg	90	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
12-04-2015	Oxycodone	15 mg	166	7	Respondent
12-07-2015	Oxycodone	15 mg	166	7	Respondent
12-22-2015	Alprazolam	1 mg	60	30	Respondent
12-29-2015	Clonazepam	2 mg	30	30	Respondent

30. During the period of on or about January 1, 2016, to December 31, 2016, respondent had two (3) office visits with patient C. According to respondent's progress notes, the visits took place on February 25 and August 24, 2016. Patient C's problems during this time generally included, but were not limited to, hypogonadism, hypothyroidism, GERD, low back pain, and opioid dependence. On January 21, 2016, respondent authorized an early refill of oxycodone 15 mg (#166). During March and April 2016, patient C was also filling prescriptions for opiates written by Dr. S.B., a bariatric surgeon, that respondent stated was related to post-surgical pain after patient C's gastric sleeve was converted to a gastric bypass to address acid reflux.[39] As a result, patient C received an additional 990 tablets of opiates (oxycodone, oxycodone/APAP, or morphine sulfate) and an additional 120 tablets of diazepam from what was already being prescribed by respondent, further increasing the risk of harm to patient C. On July 22, 2016, patient C signed a Pain Management Agreement.[40] On September 29, 2016, patient C asked for

[39] During his interview before a HQIU investigator, respondent was asked if he was aware of the number of prescriptions, primarily for opiates, that were being written by Dr. S.B., a bariatric surgeon. Respondent indicated that he was aware because patient C had allegedly told him that Dr. S.B. had prescribed some medications for post-operative pain. However, respondent was not aware "to the degree of the number of refills" because, in part, he was not using CURES on a regular basis until 2017.

[40] Respondent's use of pain management agreements for patients C and D in response to their aberrant drug behavior was an ineffective use of the pain management agreements, which should be used as soon as possible when a physician is prescribing controlled substances on a regular basis. One of the purposes of a pain management agreement is to prevent aberrant drug behavior before it occurs. Pain management agreements are also ineffective if a physician does not take active steps to monitor a patient's use of controlled substances through periodic reviews of CURES, pill counting, toxicology screens, etc., to determine if the patient is complying with the terms and conditions of the pain management agreement. The pain management agreement for patient C provided, among other things, that patient C would not use any illegal drugs, would not sell or trade his medications, would not try to obtain opioids, stimulants or anxiety medications from another doctor, would safeguard his medicine, refills would only be made during regular office hours, he would only get his prescriptions filled at Hillcrest or 24 [Hour] Rite-Aid, would submit to blood or urine testing to ensure compliance with the agreement, would (continued...)

an early refill. When asked why he needed an early refill, patient C replied he had been taking "about 6 more tabs a day" than originally prescribed, which would have pushed his total up to 30 tabs of oxycodone 15 mg per day (450 mg/day which equates to a MED of 675 mg/day). When M.G. from respondent's office followed up with patient C on September 30, 2016, to discuss his request for an early refill, his speech was slurred,[41] he was difficult to understand, and he was agitated about his refill request not being granted, as had been done in the past. M.G. wrote a detailed and lengthy account of her conversation with patient C that was electronically signed by respondent on October 10, 2016. According to the CURES report for patient C, the following prescriptions for controlled substances were filled for patient C during 2016:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-04-2016	Carisoprodol	350 mg	90	30	Respondent
01-15-2016	Oxycodone	15 mg	166	7	Respondent
01-21-2016	Oxycodone	15 mg	21	2	Respondent
01-22-2016	Oxycodone	15 mg	166	7	Respondent
01-22-2016	Oxycodone	15 mg	166	7	Respondent
01-23-2016	Alprazolam	1 mg	60	30	Respondent
01-27-2016	Clonazepam	2 mg	30	30	Respondent
01-29-2016	Oxycodone	15 mg	166	7	Respondent

(...continued)
not take medicine "at a rate greater than the prescribed rate," would bring all medications to the office, and could comply with any recommendations made in a pain management program. The copy of patient C's pain management agreement in the certified medical records is signed by patient C, but not by respondent.

[41] At one point during his interview before a HQIU investigator, respondent was asked "[w]ell, now, as you sit here today, and [the district medical consultant] has gone over the list of opioids, that was being prescribed by another physician concurrently, with your prescribing, is that of concern to you?" Respondent replied, in pertinent part, that "it is a concern...I am using the CURES on a regular basis since 2017. And during the conversations with [patient C] seeing him in the office I never again got the sense he was having adverse health effects. He wasn't slurring his speech. He wasn't ataxic. He was alert and oriented." But, in truth and fact, patient C had slurred speech, was difficult to understand, and was agitated about not getting a refill on September 30, 2018, as documented by M.G. on the same date, and electronically signed and acknowledged by respondent on October 10, 2016.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
02-01-2016	Carisoprodol	350 mg	90	30	Respondent
02-05-2016	Oxycodone	15 mg	166	7	Respondent
02-12-2016	Oxycodone	15 mg	166	7	Respondent
02-18-2016	Oxycodone	15 mg	168	7	Respondent
02-22-2016	Alprazolam	1 mg	60	30	Respondent
02-25-2016	Clonazepam	2 mg	30	30	Respondent
02-25-2016	Oxycodone	15 mg	168	7	Respondent
02-26-2016	Carisoprodol	350 mg	90	30	Respondent
02-29-2016	Triazolam	.25 mg	10	7	Other
03-01-2016	Oxycodone/APAP	10/325 mg	30	5	S.B.
03-03-2016	Oxycodone	15 mg	168	7	Respondent
03-04-2016	Oxycodone	15 mg	90	30	S.B.
03-04-2016	Diazepam	10 mg	60	30	S.B.
03-04-2016	Oxycodone	30 mg	90	30	S.B.
03-05-2016	Morphine Sulfate[42]	30 mg	30	10	S.B.
03-05-2016	Morphine Sulfate	15 mg	30	30	S.B.
03-08-2016	Testosterone-M	Unknown	10	70	Other
03-08-2016	Testosterone-P	Unknown	10	70	Other
03-10-2016	Oxycodone	15 mg	168	7	Respondent
03-11-2016	Oxycodone	15 mg	90	11	S.B.

[42] Morphine sulfate (MS Contin®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The DEA has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for MS Contin® which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of MS Contin® with benzodiazepines or other central nervous system (CNS) depressants.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
03-11-2016	Morphine Sulfate	30 mg	30	10	S.B.
03-11-2016	Oxycodone	30 mg	90	11	S.B.
03-17-2016	Oxycodone	15 mg	168	7	Respondent
03-21-2016	Morphine Sulfate	30 mg	90	30	S.B.
03-21-2016	Oxycodone	30 mg	90	11	S.B.
03-21-2016	Oxycodone	15 mg	90	11	S.B.
03-21-2016	Alprazolam	1 mg	60	30	Respondent
03-22-2016	Clonazepam	2 mg	30	30	Respondent
03-22-2016	Carisoprodol	350 mg	90	30	Respondent
03-24-2016	Oxycodone	15 mg	168	7	Respondent
03-30-2016	Oxycodone	30 mg	90	11	S.B.
03-30-2016	Oxycodone	15 mg	90	11	S.B.
03-31-2016	Oxycodone	15 mg	168	7	Respondent
04-01-2016	Morphine Sulfate	10 mg	60	30	S.B.
04-02-2016	Diazepam	10 mg	60	30	S.B.
04-07-2016	Oxycodone	15 mg	168	7	Respondent
04-13-2016	Oxycodone	15 mg	168	7	Respondent
04-20-2016	Oxycodone	15 mg	168	7	Respondent
04-20-2016	Clonazepam	2 mg	30	30	Respondent
04-21-2016	Carisoprodol	350 mg	90	30	Respondent
04-21-2016	Alprazolam	1 mg	60	30	Respondent
04-27-2016	Oxycodone	15 mg	168	7	Respondent
05-04-2016	Oxycodone	15 mg	168	7	Respondent
05-11-2016	Oxycodone	15 mg	168	7	Respondent
05-18-2016	Oxycodone	15 mg	168	7	Respondent
05-18-2016	Clonazepam	2 mg	30	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
05-18-2016	Alprazolam	1 mg	60	30	Respondent
05-18-2016	Carisoprodol	350 mg	90	30	Respondent
05-18-2016	Oxycodone	15 mg	168	7	Respondent
05-25-2016	Oxycodone	15 mg	168	7	Respondent
06-01-2016	Testosterone-M	Unknown	10	70	Other
06-01-2016	Testosterone-P	Unknown	10	70	Other
06-01-2016	Oxycodone	15 mg	168	7	Respondent
06-07-2016	Oxycodone	15 mg	168	7	Dr. H.W.
06-14-2016	Carisoprodol	350 mg	90	30	Respondent
06-14-2016	Oxycodone	15 mg	168	7	Respondent
06-14-2016	Clonazepam	2 mg	30	30	Respondent
06-14-2016	Alprazolam	1 mg	60	30	Respondent
06-21-2016	Oxycodone	15 mg	168	7	Respondent
06-28-2016	Oxycodone	15 mg	168	7	Respondent
07-05-2016	Oxycodone	15 mg	168	7	Respondent
07-11-2016	Carisoprodol	350 mg	90	30	Respondent
07-11-2016	Oxycodone	15 mg	336	14	Respondent
07-11-2016	Clonazepam	2 mg	30	30	Respondent
07-11-2016	Alprazolam	1 mg	60	30	Respondent
08-01-2016	Oxycodone	15 mg	168	7	Respondent
08-08-2016	Carisoprodol	350 mg	90	30	Respondent
08-08-2016	Alprazolam	1 mg	60	30	Respondent
08-08-2016	Clonazepam	2 mg	30	30	Respondent
08-08-2016	Oxycodone	15 mg	168	7	Respondent
08-12-2016	Testosterone-M	Unknown	10	70	Other
08-12-2016	Testosterone-P	Unknown	10	70	Other

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
08-12-2016	Oxycodone	15 mg	168	7	Respondent
08-17-2016	Clonazepam	2 mg	30	30	Respondent
08-17-2016	Alprazolam	1 mg	60	30	Respondent
08-17-2016	Carisoprodol	350 mg	90	30	Respondent
08-22-2016	Oxycodone	15 mg	168	7	Respondent
08-29-2016	Oxycodone	15 mg	168	7	Respondent
09-02-2016	Oxycodone	15 mg	168	7	Respondent
09-12-2016	Oxycodone	15 mg	168	7	Respondent
09-14-2016	Clonazepam	2 mg	30	30	Respondent
09-14-2016	Alprazolam	1 mg	60	30	Respondent
09-14-2016	Carisoprodol	350 mg	90	30	Respondent
09-19-2016	Oxycodone	15 mg	168	7	Respondent
09-19-2016	Oxycodone	15 mg	168	7	Respondent
10-03-2016	Oxycodone	15 mg	168	7	Respondent
10-07-2016	Oxycodone	15 mg	168	7	Dr. A.P.
10-10-2016	Alprazolam	1 mg	60	30	Respondent
10-10-2016	Carisoprodol	350 mg	90	30	Respondent
10-11-2016	Clonazepam	2 mg	30	30	Respondent
10-17-2016	Testosterone-M	Unknown	10	70	Other
10-17-2016	Testosterone-P	Unknown	10	70	Other
10-17-2016	Oxycodone	15 mg	168	7	Respondent
10-24-2016	Oxycodone	15 mg	168	7	Respondent
10-31-2016	Oxycodone	15 mg	168	7	Respondent
11-07-2016	Alprazolam	1 mg	60	30	Respondent
11-07-2016	Carisoprodol	350 mg	90	30	Respondent
11-07-2016	Clonazepam	2 mg	30	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
11-07-2016	Oxycodone	15 mg	168	7	Respondent
11-14-2016	Oxycodone	15 mg	168	7	Respondent
11-21-2016	Oxycodone	15 mg	168	7	Respondent
11-22-2016	Oxycodone/APAP	5/325 mg	20	2	Other
11-28-2016	Oxycodone	15 mg	168	7	Respondent
12-02-2016	Alprazolam	1 mg	60	30	Respondent
12-02-2016	Carisoprodol	350 mg	90	30	Respondent
12-02-2016	Clonazepam	2 mg	30	30	Respondent
12-05-2016	Oxycodone	15 mg	168	7	Respondent
12-12-2016	Oxycodone	15 mg	168	7	Respondent
12-19-2016	Oxycodone	15 mg	168	7	Respondent
12-23-2016	Oxycodone	15 mg	168	7	Respondent
12-29-2016	Alprazolam	1 mg	60	30	Respondent
12-29-2016	Carisoprodol	350 mg	90	30	Respondent
12-29-2016	Clonazepam	2 mg	30	30	Respondent
12-30-2016	Oxycodone	15 mg	168	7	Respondent

31. Throughout his course of treatment of patient C, respondent failed to adequately respond to several warning signs indicating misuse, abuse and/or diversion of controlled substances and did not take adequate risk screening measures to prevent the misuse, abuse and/or the diversion of the controlled substances that he was prescribing. These warning signs included, but were not limited to, requests for early refills, drug intoxication, excessive use of controlled substances, a pharmacist voicing concerns over the controlled substances being prescribed to patient C, and obtaining controlled substances from multiple prescribers and pharmacies.

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32. Respondent committed gross negligence in his care and treatment of patient C which included, but was not limited to, the following:

(a) Respondent failed to properly evaluate and manage patient C's chronic nonmalignant pain;

(b) Respondent repeatedly prescribed controlled substances, primarily opioids, to treat patient C's chronic nonmalignant pain without, among other things, sufficiently documenting the effect of patient C's pain on his function and quality of life, without following a rational treatment plan with measurable stated objectives including, but not limited to, pain level and function, and without adjusting treatment pursuant to a rationale and clearly documented treatment plan;

(c) Respondent repeatedly prescribed controlled substances, primarily benzodiazepines, to treat patient C's anxiety without, among other things, a sufficient and clearly documented history, physical examination and/or rationale treatment plan;

(d) Respondent repeatedly prescribed various controlled substances including, but not limited to, opioids, benzodiazepines, and/or other CNS depressants, without providing and documenting adequate informed consent;

(e) Respondent repeatedly prescribed controlled substances including, but not limited to, opioids, benzodiazepines, and/or other CNS depressants, without being cognizant of aberrant drug behavior and without timely and adequate risk screening measures to address aberrant drug behavior including, but not limited to, effectively using pain management agreements in a non-reactive manner, periodically reviewing CURES, obtaining information from pharmacies, utilizing pill counts, and/or properly coordinating care with other physicians and prescribers;

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(f) Respondent repeatedly increased the risk of harm to patient C, though his concurrent prescribing of opioids, benzodiazepines, carisoprodol (Soma), and/or other CNS depressants; and

(g) Respondent excessively prescribed various controlled substances including, but not limited to, opiates, benzodiazepines, and/or other CNS depressants.

PATIENT D

33. According to respondent, he had treated Patient D, since approximately 1992. During the period of on or about January 1, 2013, to December 31, 2013, respondent had eleven (11) office visits with patient D, a then-71- year old male. According to respondent's progress notes, the visits took place on January 7, February 5, March 12, May 28 (chief complaint of "follow up from fall" after taking "a second 5 mg zolpidem tablet" with assessment of "frequent falls" with patient "advised not to increase his norco dosing given his frequent falls"), June 24, August 23, September 19, October 10, November 7, November 18, and December 31, 2017. Patient D's problems during this time generally included, but were not limited to, rotator cuff repair, hypertension, edema and pain associated shoulder surgeries on January 24 (right rotator cuff repair) and October 17, 2013 (right shoulder reversal). On June 14, 2013, respondent entered a "chronic care update" indicating "[n]otice sent to Dr. [A's] office to avoid filling pain medications unless managing post op pain or on emergency basis when this office cannot be reached." According to opiate medications listed on respondent's "current meds" list of December 31, 2013, patient D's MED at the end of 2013 was at least 184 mg/day.[43] A pain management agreement[44] was executed by respondent and patient D on June 24, 2013. During

[43] This computation is based on 120 mg of hydrocodone/APAP per day and 16 mg of hydromorphone per day. This computation does not include opiates that were being prescribed by other health care practitioners.

[44] The pain management agreement for patient D provided, among other things, that patient D would not use any illegal drugs, would not sell or trade his medications, would not try to obtain opioids, stimulants or anxiety medications from another doctor, would safeguard his medicine, refills would only be made during regular office hours, he would only get his prescriptions filled at CVS in Mission Valley, would submit to blood or urine testing to ensure compliance with the agreement, would not take medicine "at a rate greater than the prescribed (continued...)

2013, patient D had his prescriptions filled at approximately seven (7) different pharmacies. According to the CURES report for patient D, the following prescriptions for controlled substances were filled for patient D during 2013:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-08-2013	Temazepam	15 mg	30	30	Respondent
01-16-2013	Hydrocodone/APAP	10/325 mg	60	5	Other
01-16-2013	Zolpidem Tartrate	5 mg	60	30	Respondent
01-16-2013	Oxycodone/APAP	10/325 mg	60	5	Other
01-16-2013	Temazepam	15 mg	30	30	Respondent
01-18-2013	Temazepam	15 mg	60	30	Respondent
01-20-2013	Hydrocodone/APAP	10/325 mg	240	20	Respondent
01-28-2013	Oxycodone/APAP	10/325 mg	80	13	Other
02-05-2013	Oxycodone/APAP	10/325 mg	80	7	Other
02-05-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
02-12-2013	Oxycodone/APAP	10/325 mg	80	7	Other
02-19-2013	Oxycodone/APAP	10/325 mg	80	6	Other
03-02-2013	Temazepam	15 mg	60	30	Respondent
03-04-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
03-13-2013	Zolpidem Tartrate	5 mg	60	30	Respondent
03-29-2013	Hydrocodone/APAP	10/325 mg	20	5	Other
03-30-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
03-30-2013	Temazepam	15 mg	60	30	Respondent
04-10-2013	Zolpidem Tartrate	5 mg	60	30	Respondent
04-25-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent

(...continued)
rate," would bring all medications to the office, and could comply with any recommendations made in a pain management program.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
05-06-2013	Temazepam	15 mg	60	60	Respondent
05-11-2013	Zolpidem Tartrate	5 mg	60	30	Respondent
05-22-2013	Hydrocodone/APAP	5/500 mg	20	3	Other
05-23-2013	Hydrocodone/APAP	7.5/325 mg	120	15	Respondent
05-28-2013	Hydrocodone/APAP	7.5/325 mg	120	15	Respondent
06-04-2013	Hydrocodone/APAP	10/325 mg	80	13	Other
06-11-2013	Temazepam	15 mg	60	30	Respondent
06-24-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
07-16-2013	Temazepam	15 mg	60	30	Respondent
07-21-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
07-31-2013	Zolpidem Tartrate	10 mg	30	30	Other
07-31-2013	Oxycodone/APAP	10/325 mg	19	4	Other
08-18-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
08-24-2013	Oxycodone /APAP	7.5/325 mg	240	30	Respondent
09-15-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
09-19-2013	Oxycodone/APAP	10/325 mg	120	15	Respondent
10-03-2013	Oxycodone/APAP	10/325 mg	120	15	Respondent
10-15-2013	Hydrocodone/APAP	10/325 mg	240	30	Respondent
10-16-2013	Oxycodone/APAP	10/325 mg	120	15	Respondent
10-21-2013	Hydromorphone	2 mg	80	10	Other
10-24-2013	Hydromorphone	4 mg	90	15	Other
10-31-2013	Oxycodone/APAP	10/325 mg	120	15	Respondent
11-06-2013	Hydrocodone/APAP	10/325 mg	90	7	Respondent
11-06-2013	Hydromorphone	2 mg	120	15	Respondent
11-18-2013	Hydromorphone	2 mg	120	15	Respondent
11-19-2013	Hydrocodone/APAP	10/325 mg	240	26	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
12-02-2013	Hydromorphone	2 mg	60	7	Dr. H.W.
12-08-2013	Hydromorphone	2 mg	60	7	Dr. H.W.
12-13-2013	Hydrocodone/APAP	10/325 mg	240	20	Respondent
12-17-2013	Hydromorphone	2 mg	60	7	Respondent
12-22-2013	Hydromorphone	2 mg	120	15	Respondent
12-31-2013	Morphine Sulfate	15 mg	90	3	Respondent

34. During the period of on or about January 1, 2014, to December 31, 2014, respondent had six (6) office visits with patient D. According to respondent's progress notes, the visits took place on March 27, April 29, June 16, July 2, August 15 (chief complaint listed as "Recent fall caused injury to right side of face" with patient describing fall and then requesting early refill – "vacation over-ride" on his Norco with respondent granting "vacation override on norco for pick up of 37d [days] time 8/day #296") and November 14, 2014. Patient D's problems during this time generally included, but were not limited to, HTN, chest pain (which resolved), shoulder pain, opioid dependence, facial abrasion from fall on August 12, chronic recurrent major depressive disorder and anxiety. On January 24, 2014, respondent approved an early refill because patient D was traveling to Paris in a few days with another vacation over-ride on August 15, 2014. During 2014, patient D had his prescriptions filled at approximately five (5) different pharmacies, which was a violation of the pain management agreement he had signed. At the end of 2014, patient D's MED was at least 170 mg/day. According to the CURES report for patient D, the following prescriptions for controlled substances were filled for patient D during 2014:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-10-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
01-24-2014	Morphine Sulfate	15 mg	90	20	Respondent
02-04-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
02-18-2014	Hydromorphone	15 mg	90	30	Dr. D.B.
03-04-2014	Hydrocodone/APAP	10/325 mg	240	20	Dr. D.B.

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
03-17-2014	Morphine Sulfate	15 mg	90	30	Respondent
03-27-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
04-15-2014	Morphine Sulfate	15 mg	90	30	Respondent
04-23-2014	Hydrocodone/APAP	10/325 mg	240	30	Respondent
04-29-2014	Morphine Sulfate	30 mg	90	30	Respondent
05-20-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
05-26-2014	Morphine Sulfate	30 mg	90	30	Respondent
06-16-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
06-20-2014	Morphine Sulfate	30 mg	90	30	Respondent
07-08-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
07-17-2017	Morphine Sulfate	30 mg	90	30	Respondent
07-30-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
08-09-2014	Morphine Sulfate	30 mg	90	30	Respondent
08-28-2014	Hydrocodone/APAP	10/325 mg	296	37	Respondent
09-04-2014	Morphine Sulfate	30 mg	90	30	Respondent
09-26-2014	Hydrocodone/APAP	10/325 mg	240	20	Dr. D.B.
09-27-2014	Morphine Sulfate	30 mg	90	30	Dr. D.B.
10-24-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
10-25-2014	Morphine Sulfate	30 mg	90	30	Respondent
11-18-2014	Hydrocodone/APAP	10/325 mg	240	20	Respondent
11-23-2014	Morphine Sulfate	30 mg	90	30	Respondent
12-15-2014	Hydrocodone/APAP	10/325 mg	240	20	Dr. A.P.
12-21-2014	Morphine Sulfate	30 mg	90	30	Dr. A.P.

35. During the period of on or about January 1, 2015, to October 30, 2015, respondent had seven (7) office visits with patient D. According to respondent's progress notes, the visits took place on January 8, February 10, March 19, April 28, July 16, September 30 (patient

indicating that will be moving to Kentucky with respondent noting "patient may want to attempt taper pain management after establishing care in Kentucky [-] consider suboxone program vs taper to hydrocodone alone"), and October 26, 2015 (final visit before patient D left for Kentucky). Patient D's problems during this time generally included, but were not limited to, shoulder pain, GERD, HTN, major depressive disorder, chest pain associated with pericarditis, and opioid dependence. As of the date of respondent's last visit with patient D on October 26, 2015, patient D's MED was approximately 210 mg per day. During 2014, patient D had his prescriptions filled at approximately five (5) different pharmacies, which was a violation of the pain management agreement he had signed. According to the CURES report, the following prescriptions for controlled substances were filled for patient D during 2015:

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
01-08-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
01-29-2015	Oxycodone/APAP	5/325 mg	10	1	Other
02-19-2015	Oxycodone/APAP	5/325 mg	10	10	Other
03-05-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
03-11-2015	Morphine Sulfate	30 mg	90	30	Respondent
04-08-2015	Morphine Sulfate	30 mg	90	30	Respondent
04-12-2015	Oxycodone/APAP	5/325 mg	20	5	Other
04-28-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
05-05-2015	Morphine Sulfate	30 mg	90	30	Respondent
05-27-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
07-16-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
07-21-2015	Morphine Sulfate	30 mg	90	30	Respondent
08-13-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
08-17-2015	Morphine Sulfate	30 mg	90	30	Respondent
08-27-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
08-27-2015	Morphine Sulfate	30 mg	90	30	Respondent

Date Filled	Drug Name	Strength	Quantity	Days	Prescriber
09-30-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
09-30-2015	Morphine Sulfate	30 mg	90	30	Respondent
10-26-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent
10-26-2015	Morphine Sulfate	30 mg	90	30	Respondent
10-30-2015	Morphine Sulfate	30 mg	90	30	Respondent
10-30-2015	Hydrocodone/APAP	10/325 mg	240	20	Respondent

36. Throughout his course of treatment of patient D, respondent failed to adequately respond to several warning signs indicating misuse, abuse and/or diversion of controlled substances and did not take adequate risk screening measures to prevent the misuse, abuse and/or the diversion of the controlled substances that he was prescribing. These warning signs included, but were not limited to, having prescriptions filled at multiple pharmacies, obtaining controlled substances from multiple prescribers, overuse of prescribed drugs, and patient D's history of falls.

37. Respondent committed gross negligence in his care and treatment of patient D which included, but was not limited to, the following:

(a) Respondent failed to properly evaluate and manage patient D's chronic nonmalignant pain;

(b) Respondent repeatedly prescribed controlled substances, primarily opioids, to treat patient D's chronic nonmalignant pain without, among other things, sufficiently documenting the effect of patient D's pain on his function and quality of life, without following a rational treatment plan with measurable stated objectives including, but not limited to, pain level and function, and without adjusting treatment pursuant to a rationale and clearly documented treatment plan;

(c) Respondent repeatedly prescribed controlled substances, primarily benzodiazepines, to treat patient D's anxiety without, among other things, a sufficient and clearly documented history, physical examination and/or

rationale treatment plan;

(d) Respondent repeatedly prescribed various controlled substances including, but not limited to, opioids, benzodiazepines, and/or other CNS depressants, without providing and documenting adequate informed consent;

(i) Respondent repeatedly prescribed controlled substances including, but not limited to, opioids, benzodiazepines, and/or other CNS depressants, without being cognizant of aberrant drug behavior and without timely and adequate risk screening measures to address aberrant drug behavior including, but not limited to, effectively using pain management agreements in a non-reactive manner, periodically reviewing CURES, obtaining information from pharmacies, utilizing pill counts, and/or properly coordinating care with other physicians and prescribers;

(f) Respondent excessively prescribed various controlled substances including, but not limited to, opiates, benzodiazepines and/or other CNS depressants; and

(g) Respondent occasionally exceeded the recommended maximum daily dosage for acetaminophen (APAP).

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

38. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, and D, as more particularly alleged in paragraphs 8 through 37, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

39. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated a lack of knowledge regarding opioids and their safe prescription, along with other pharmacological issues, as it pertained to his prescribing of controlled substances to patients B, C and D, as more particularly alleged in paragraphs 16 through 37, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

40. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing drugs or treatment to patients A, B, C and D, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 8 through 37, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Record)

41. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of patients A, B, C and D, as more particularly alleged in paragraphs 8 through 37, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G58692, issued to respondent Frank Gilman, M.D.;

2. Revoking, suspending or denying approval of respondent Frank Gilman, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering respondent Frank Gilman, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 2, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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